GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

Health Regulation
& Licensing Administration

SENT VIA FACSIMILE and US Mail

January 17, 2008

David Carrington
Director
Innovative Life Solutions
6475 New Hampshire Ave.
Hyattsville, Maryland 20783

RE: 7416 Blair Road, NW

Dear Mr. Carrington:

On January 10, 2008 the Department of Health, Health Regulation and Licensing Administration, conducted an annual recertification and licensure survey at your facility identified above to determine if your facility was in compliance with Federal participation requirements for Intermediate Care Facilities for the Mentally Retarded participating in the Medicaid program. This survey determined your facility was not operating in substantial compliance with the participation requirements. Specifically, your facility was found in noncompliance with the following conditions of participation:

[1]42 CFR 483.410 – Governing Body and Management
42 CFR 483.460 – Health Care Services

A list of deficiencies constituting the reason for the noncompliance is enclosed. You have an opportunity to correct the deficiencies that were cited. If you submit a credible allegation of compliance to this office by **February 14, 2008** (35 days after completion of the survey) a surveyor from this office will revisit your visit within 3 business days (**February 20, 2008**). If the revisit result in a determination that you have corrected deficiencies and your facility is in substantial compliance with the Conditions of Participation, this office will recommend to the Department of Health, Medical Assistance Administration (MAA), recertification of your provider agreement for this facility.

[1] Reference is to Title 42 of the Code of Federal Regulations.

This office will recommend termination of your federal participation if **(1)** this office does not receive a written credible allegation of compliance by **February 14, 2008** or **(2)** if you submit a credible allegation of compliance, but are found not to have been in substantial compliance by **February 25, 2008, forty-five** (45) days after the survey completion date. We will recommend that the termination date be **April 9, 2008,** ninety- (90) days after the survey completion date.

Should the Health Regulation Administration recommend termination of your federal participation, the MAA will contact you with its determination. The MAA will also apprise you of your hearing rights pursuant to 42 CFR 431.151 – 154.

Please note that, if your participation in the Medicaid program is terminated, your facility will not be readmitted to the program unless you can demonstrate to this office that the reason for termination has been removed and there is a reasonable assurance that it will not recur.

If you have any questions regarding this matter, please contact Ms. Sheila Pannell, Supervisory Health Services Program Specialist, Intermediate Care Facilities Division on (202) 442-5888.

Sincerely,

Patricia W. VanBuren

Patricia W. VanBuren
Program Manager

Enclosures

cc: Medical Assistance Administration
Department on Disability Services

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

Health Regulation Administration

SAMPLE SELECTION FORM

Survey Period
From: **January7, 2008**
To: **January 10, 2008**

[redacted]

Provider Name: **Innovative Life Solutions** Provider Number: **O9G212**

Names	Functional Level	Core	Add-On	Client Identifiers
JOSEPH STROUD	SEVERE	x		CLIENT #1
Clifford Brown	PROFOUND	x		CLIENT #2
PERRY LIGHTSEY	SEVERE			CLIENT #3
MARK VLAHOV	SEVERE			CLIENT #4

M. Walker/A. Brannum
Surveyor(s)

January 11, 2008
Date

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G212	A. BUILDING _____ B. WING _____	01/10/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOULTIONS, INC	7416 BLAIR ROAD, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from Janurary 7, 2008 through January 10, 2008. The survey was initiated using the fundamental survey process; however, due to the deficient practice in the Condition of Client Protections, the survey process was extended to a full survey. A random sample of two clients was selected from a resident population of four males with various disabilities. The survey findings were based on observations in the group home and one day program, and interviews with residential, day program, nursing and administrative staff. Review of records, including review of unusual incidents and investigation reports was also conducted. The facility was deficit in the Conditions of Participation in Governing Body and Management and Health Care Services.	W 000		
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: The facility's governing body failed to maintain general operating direction over the facility [Cross Refer to W104]. The systemic effect of these practices results in the failure of the governing body to adequately manage and govern the facility and to ensure its compliance with the Condition of Health Care. [Cross Refer to W318]	W 102		
W 104	483.410(a)(1) GOVERNING BODY	W 104		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, staff interviews, and record reviews the governing body failed to ensure that the facility exercised general policy, and operating direction over the facility. The finding includes: 1. Cross Refer to W 322.1. The Governing Body failed to establish and implement policies and procedures to ensure that the medical consultants recommendations were addressed in a timely manner by the Primary Care Physician for one of two clients in the sample. 2. Cross Refer to W 322.2. The Governing Body failed to ensure that medical services provided a complete diet order on the physician's order sheet (POS) for one of two clients in the sample. 3. Cross Refer to W331. The governing body failed to ensure that the facility's nursing staff provided nursing services in accordance with the needs of one of two clients in the sample. 4. Cross Refer to W338. The governing body failed to ensure that the facility's nursing staff provided timely follow-up on referrals in accordance with the needs of one of one of two clients in the sample. 4. Cross Refer to W368. The governing body failed to ensure that the facility's nursing staff administered medications in compliance with the	W 104		

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W 104	Continued From page 2 physician's orders for one of two clients in the sample.	W 104		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to ensure that outside services met the needs for one of the two clients in the sample. (Client #1). The findings include: Observations conducted at the day program on January 8, 2008 at starting at 9:15 AM revealed Client #1's 1:1 staff had removed his adaptive helmet while sitting at the table with his peers. Further observations at 9:20 AM revealed Client #1 was transported to the water fountain by his 1:1 staff. The 1:1 staff was observed to support Client #1 with ambulating by keeping his overhand at his pelvis/trunk area, and by keeping his body close to the client's without interfering with his movements. Interview with the day program lead counselor at approximately 9:40 AM revealed that he was aware of the "new helmet and ambulation protocol" for Client #1, but had not received training on protocol. Further interview with the day program Case Manager at 9:51 AM revealed that they have not received a copy of the Client #1's new protocols. Review of Client #1's records revealed no evidence of the Helmet and Ambulation Protocols located in the records.	W 120		

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W 120	Continued From page 3 Interview with the acting Qualified Mental Retardation Professional (QMRP)/Program Manager on the same day at approximately 12:00 PM revealed that she had just faxed over the new "Helmet and Ambulation Protocols" dated December 24, 2007 over to Client #1's day program. Further interview with the QMRP acknowledges that the day program staff have not received training on the new protocols.	W 120		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to establish a system that would ensure clients that were informed of their risks and benefits of their medication for one of the two clients in the sample. (Client #2) The finding includes: Client #2 was observed during the evening medication pass on January 7, 2008, at approximately 4:09 PM being administered Chlorpromazine 150 mg by mouth. Interview with the Licensed Practical Nurse (LPN) on January 7, 2008 at approximately 4:15 PM revealed that Client #2 was prescribed the medication for behavior management. Review of the physician's order sheet (POS) dated December 1, 2007 on	W 124		

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W 124	Continued From page 4 January 9, 2008 at approximately 11:15 AM revealed that Client #2 has diagnoses of Intermittent Explosive Disorder (IED)and Schizophrenia; Chronic Undifferentiated Type and was prescribed Chlorpromazine 150 mg by mouth twice a day and Lithium 150 mg every day for seven days. Lisinopril 5 mg. by mouth every day for behavior management. Interview with the Program Manager on January 8, 2007 at approximately 3:00 PM revealed that Client #2's mother was very involved in his life but is not the client's legal guardian. Review of Client #2's, psychological assessment dated March 19, 2007 on January 9, 2008 at approximately 11:18 AM revealed that the client does not have the ability to make decisions on his behalf regarding habilitation planning, residential placement, finances, treatment and medical matters. There was no documented evidence that the facility informed Client #2's mother of the health benefits and risks of treatment associated with the use of his psychotropic medications. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity.	W 124		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on interview, and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination of services for two of two clients in the sample. (Client #1 and Client #2)	W 159		

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W 159	Continued From page 5 The finding includes: 1. Cross refer to W120. The QMRP failed to ensure that Client #1's day program was trained and received a copy of his new "Helmet and Ambulation Protocol. 2. Cross refer to W252. The QMRP failed to ensure that data had been collected in accordance with the IPPs for Client #1. 3. The QMRP failed to coordinate services with the Interdisciplinary Team (IDT) to ensure that the Physical Therapist's (PT's) recommendation for Client # 2 was addressed as evidenced by: Observation of Client #2 at the day program on January 8, 2008 at approximately 10:30 AM-12:00 PM revealed that the client sat in chairs and ambulated in a forward bent over manner. Review of Client #2's physician's order sheet (POS) dated December 1, 2007 on January 8, 2008 at approximately 2:11 PM revealed that the client has a diagnosis of kyphoscoliosis. Review of the PT assessment dated March 21, 2007 on January 9, 2008 at approximately 11:36 AM revealed that Client #2 was recommended to be considered for a scapular harness to promote more upright posture.	W 159		
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by:	W 192		

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W 192	Continued From page 6 Based on observation, staff interview and record review, the facility failed to effectively train staff to implement emergency measures for four of four clients in the facility. (Clients #1, #2, #3 and #4) The findings include: 1. The Program Manager/acting Qualified Mental Retardation Professional (QMRP) failed to ensure that all staff had been effectively trained to implement emergency measures for four of four clients in the facility as evidenced by: Interview with the House Manager and QMRP on January 9, 2008 at approximately 1:15 PM revealed that all staff was not trained in CPR. Record review on January 9, 2008 at approximately 1:30 PM revealed that six (6) out of twelve direct care staff did not have current CPR certifications. Further review of the records revealed that two consultants (Registered Nurse and Licensed Practical Nurse) were without current CPR certification. There was no documented evidence that all direct care staff including consultants had CPR training and current CPR certifications. 2. The QMRP failed to ensure that all staff had been effectively trained to implement emergency measures for four of four clients in the facility as evidenced by: Interview with the House Manager on January 10, 2008 at approximately 8:47 AM revealed that all staff was not trained in First Aid. Record review on January 10, 2008 at approximately 9:00 AM revealed that six (6) out of twelve direct care staff did not have current First Aid certifications. Further review of the records revealed that one	W 192		

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W 192	Continued From page 7 consultant (Registered Nurse) was without current First Aid certification. There was no documented evidence that all direct care staff including consultants had First Aid training and current First Aid certifications.	W 192		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observations interview, and record review, the facility failed to ensure that data was collected in the form and required frequency for one of two clients included in the sample. (Client #1) The findings include: The facility failed to ensure that data had been collected in accordance with the IPPs for Client #1, which was necessary for a functional assessment of the client's progress as evidenced below: 1. Evening observations conducted on January 7, 2008 at approximately 4:37 PM revealed Client #1 went for a community walk with his 1:1 staff to identify survival signs. Further observations conducted at the day program on January 8, 2007 at approximately 9:33 AM revealed Client #1 identifying survival signs at 9:33 AM. (i.e. Do not touch, Do not enter, keep out, and exit signs). Interview with 1:1 staff on January 7, 2008 at approximately 6:21 PM revealed that Client #1	W 252		

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W 252	Continued From page 8 has a program to identify survival signs. Review of the client's Individual Program Plan (IPP) dated April 13, 2007 on January 8, 2008 at approximately 11:23 AM revealed a program objective which read "the client will discriminate (3) universal safety survival signs commonly found in the home, day program, and community environment with 60% accuracy per session for 3 consecutive months. Review of the data collection sheets on January 9, 2008 at 3:16 revealed no documentation for the days of 1/2/08, 9/3/07, 9/5, 9/12, 9/14, and 9/21. Interview with the QMRP on January 9, 2008 at approximately 3:32 PM acknowledged that the data was not being collected in accordance with the IPP. 2. Observations conducted on January 8, 2008 at approximately 9:24 AM at the day program revealed Client #1 identifying monetary coins at the table with his 1:1 staff. Interview with 1:1 staff on January 8, 2008 at approximately 9:51 AM revealed that Client #1 has a program to identify coins. Review of the client's Individual Program Plan (IPP) dated April 13, 2007 on January 8, 2008 at approximately 11:25 AM revealed a program objective which read "the client will identify coins with 50% accuracy per session for three consecutive months. Review of the data collection sheets on January 9, 2008 at 3:14 PM revealed no documentation for the days of 10/10/07, 10/17, 10/24, 9/3/07, and 8/31/07. Interview with the QMRP on January 9, 2008 at approximately 3:30 PM acknowledged that the data was not being collected in accordance with the IPP. 3. Further review of Client #1's IPP on January 8, 2008 at approximately 11:27 AM revealed and	W 252		

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W 252	Continued From page 9 objective which read "the client will use a personal talker in response to query for personal information with 80% accuracy per session for 3 consecutive months. Interview with the 1:1 staff on January 7, 2008 at approximately 6:21 PM revealed that Client #1 has a communication device that he speaks into to record and repeat his personal information. Review of the data collection sheets on January 9, 2008 at 3:14 PM revealed no documentation for the days of 8/31/07, 9/3/07, 10/16/07, and 10/31/07. Interview with the QMRP on January 9, 2008 at approximately 3:30 PM acknowledged that the data was not being collected in accordance with the IPP.	W 252		
W 318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on observation, interviews, and record reviewed, the facility failed to effectively train staff to implement emergency measures [Cross Refer to W192]; failed to provide preventive and general health care services to meet the needs of the clients [Cross Refer to W322]; the facility failed to establish systems to provide health care monitoring and identify services that would ensure nursing services were provided in accordance with clients needs [Cross Refer to W331]; failed to ensure timely medical follow up failed to ensure health services were provided to meet the needs of the clients [Cross Refer to W338] and failed to ensure that medications were administered in accordance to physician's orders. [Cross Refer to W368]	W 318		

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W 318	Continued From page 10 The results of these systemic practices results in the demonstrated failure of the facility to provide health care services.	W 318		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility's medical services failed to address a recommendation made by a medical consultant for one of two clients in the sample (Client #2) and the facility failed to provide a complete diet order on the physician's order sheet (POS) for one of two clients in the sample. (Client #2) The findings include: 1. Review of the nephrology consult dated December 17, 2007, on January 9, 2008 at approximately 11: 00 AM revealed that Client #2 had a diagnosis of stable chronic kidney disease; Stage 2, probably from lithium toxicity due to long standing use. Further review of the nephrology consult revealed a recommendation that Client #2's dosage of Lisinopril 5 mg. by mouth every day be increased to Lisinopril 10 mg. by mouth every day. Review of the Medication Administration Record (MAR) dated January, 2008 at approximately 4:25PM revealed that Client #2 was administered Lisinopril 5 mg. by mouth. Review of the physician's order sheet (POS) dated December 1, 2007on January 9, 2008 at approximately 11:10 AM revealed that	W 322		

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W 322	Continued From page 11 Client #2 had a diagnosis of hypertension and was prescribed Lisinopril 5 mg. by mouth every day for blood pressure management. In an interview with the Licensed Practical Nurse (LPN) on January 9, 2008 at approximately 2:00 PM it was acknowledged that Client #2 was administered Lisinopril 5 mg. by mouth every day. Further interview revealed that the Primary Care Physican (PCP) was made aware of the nephrologist 's recommendation. Review of a nursing progress note dated December 18, 2007on January 9, 2008 at approximately 2:15 PM revealed " [Client #2] visted the nephrologist yesterday as scheduled due to abn. [abnormal] renal results per PCP order, MD notified of all recommendation[s] via voice mail and consult form with information faxed to him ...awaits return call." There was no documented evidence that the PCP addressed the nephrologist 's recommendation that Client #2 's Lisinopril be increased from 5mg. every day to 10mg every day. 2. Observation at the day program during the lunch meal on January 8, 2008 at approximately 11:00 AM revealed that Client #2 was served a low fat, low cholesterol, no added salt (NAS) chopped diet. Interview with the direct care staff on January 8, 2007 at approximately 11:10 AM revealed that Client #2 was served a low fat, low cholesterol, no added salt (NAS) chopped diet because he had hypertension and high cholesterol. Review of the physician's order sheet (POS) dated December 1, 2007on January 8, 2008 at approximately 2:11 PM revealed that Client #2 was on a low fat, low cholesterol chopped diet. Review of the Nutritional Assessment dated March 19, 2007 on January 9, 2008 at approximately 10:40 AM indicated that	W 322		

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W 322	Continued From page 12 Client #2 was on a low fat, low cholesterol, no added salt (NAS) chopped diet. There was no documented evidence that the NAS retriction was included on the POS.	W 322		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to ensure nursing services in accordance with the needs of two of two clients in the sample. (Client #1 and Client #2) The findings include: 1. Cross Refer to W338. The facility's nursing staff failed to ensure timely follow-up on referrals in accordance with the needs of one of the two clients in the sample. 2. Cross Refer to W368. The facility's nursing staff failed to ensure that medications were given in compliance with the physician's orders for one of the two clients in the sample. 3. The facility's nursing staff failed to ensure that Client #2's psychiatrist was aware of his abnormal lithium level as evidenced by: Review of a laboratory study dated July 20, 2007 on January 8, 2008 at approximately 2:45 PM revealed a lithium level of 1.23 MEQ/L [reference range 0.60-1.20 MEQ/L]. Further review revealed a recommendation from the Primary Care Physician (PCP) that the lithium level of 1.23	W 331		

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	09G212	A. BUILDING _____ B. WING _____	01/10/2008

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W 331	Continued From page 13 MEQ/L be forwarded to the psychiatrist. In an interview with the Licensed Practical Nurse (LPN) on January 8, 2008 at approximately 10:10 AM revealed that the psychiatrist was made aware of the abnormal lithuim level. Review of the medical record and psychotropic medication review dated July, 2007on dated January 9, 2008 at approximately 10:05 AM revealed that there was no documented evidence that the psychiatrist was made aware of the abnormal lithuim level. 4. The facility's nursing staff failed to complete Client #2's Annual Health Services Summary (AHSS) as evidenced by: Review of Client #2's AHSS dated August 5, 2007, on January 8, 2008 at approximately 1:50 PM revealed that the AHSS did not include a review of the client's body systems on pages two and three of the summary. 5. The facility's nursing staff failed to update Client #1's Health Management Care Plan (HMCP) as evidenced by: Review of Client #1's Health Management Care Plan (HMCP) dated January 7, 2007 on January 8. 2008 at approximately 11:30 AM revealed that the HMCP had not been updated to include the client's new helmet and ambulation protocol due to frequent injuries from falls. Interview with the facility's Licensed Pratical Nurse (LPN) on January 9, 2008 at approximately 11:29 AM revealed that the Registered Nurse has not updated the HMCP to include the new protocols. Further interview with the LPN revealed that the protocols needs to be added to the HMCP in regards to Clien t#1's health and safety.	W 331		

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W 331	Continued From page 14 6. The facility's nursing staff failed to update Client #2's HMCP as evidenced by: a. Review of Client #2's HMCP dated January 7, 2007 on January 8. 2008 at approximately 2:00 PM revealed that the HMCP had not been updated to include the client's diagnosis of hypertension. Review of the physician's order sheet (POS) dated December 1, 2007on January 9, 2008 at approximately 11:10 AM revealed that Client #2 had a diagnosis of hypertension and was prescribed Lisinopril 5 mg. by mouth every day for blood pressure management. In an interview with the LPN on January 9, 2008 at approximately 2:20 PM it was acknowledged that the HMCP had not been updated to include the Client #2's diagnosis of hypertension. There was no documented evidence that the HMCP had been updated after January 7, 2007 to include the diagnosis of hypertension. b. Review of Client #2's HMCP dated January 7, 2007 on January 8, 2008 at approximately 2:00 PM revealed that the HMCP had not been updated to include the client's diagnosis of osteoporosis. Review of the POS dated December 1, 2007on January 9, 2008 at approximately 11:20 AM revealed that Client #2 had a diagnosis of osteoporosis and was prescribed Fosamax one tablet weekly. Review of the Bone Densitometry consult dated October 9, 2007, on January 8, 2008 at approximately 2:15PM revealed that Client #2 had osteoporisis of the lumbar spine and hip with a high risk for fractures. In an interview with the LPN on January 8, 2008 at approximately 2:25 PM it was acknowledged that the HMCP had not been updated to include the Client #2's diagnosis of osteoporosis. There was no documented	W 331		

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W 331	Continued From page 15 evidence that the HMCP had been updated after January 7, 2007 to include the diagnosis of osteoporosis.	W 331		
W 338	483.460(c)(3)(v) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must result in any necessary action (including referral to a physician to address client health problems). This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility's nursing services failed to ensure timely follow-up on referrals in accordance with the needs of one of the two clients in the sample. (Client #2) The findings include: 1. The facility's nursing services failed to ensure that Client #2's audiology appointment was conducted timely as evidenced below: Review of an audiology consult dated June 22, 2007 on January 8, 2008 at approximately 3:45 PM revealed a recommendation that the client return to the audiology clinic in one month for removal of cerumen. In an interview with the Licensed Practical Nurse (LPN) on January 8, 2008 at approximately 3:47 PM it was revealed that Client #2 did not go back to the audiology clinic until January 4, 2008. There was no documented evidence that the client returned for an audiology appointment in a timely manner. [Note: Review of the audiology consult dated January 4, 2008 on January 8, 2008 revealed that	W 338		

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W 338	Continued From page 16 Client #2 was uncooperative and was unable to be examined.] 2. The facility's nursing services failed to ensure that Client #2's lithium levels were obtained in a timely manner as evidenced below: a. Review of the psychotropic medication review dated September 19, 2007 on January 8, 2008 at approximately 8:38 AM revealed a recommendation that Client #2 have a repeat lithium level. Interview with the LPN on January 9, 2007 at approximately 10:00AM revealed that Client #2 did go to the laboratory to have his lithium level drawn; however the hospital failed to draw the blood for the lithium level. Review of laboratory studies on January 9, 2008 at approximately 10:30AM revealed that there were no lithium levels available for the month of September in the medical record. There was no documented evidence that the client's lithium level was obtained as in a timely manner. b. Review of the psychotropic medication review dated October 19, 2007 on January 8, 2008 at approximately 9:00 AM revealed a recommendation that Client #2 have a repeat lithium level obtained "stat" [immediately]. Interview and record review with the LPN on January 9, 2007 at approximately 1:00PM revealed that Client #2 refused to have his lithium level drawn on October 18, 2007 and October 23, 2007. Further interview revealed that Client #2 was sent to the laboratory to did his lithium level obtained on October 26, 2006. Review of a nursing progress note dated November 30, 2007 on January 9, 2008 at approximately 1:15 PM revealed that the hospital had not drawn the lithium level on October 26, 2007. Review of a	W 338		

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W 338	Continued From page 17 pharmacy medication review document dated November 29, 2007 revealed a recommendation to repeat the lithium level. There was no documented evidence that the client's lithium level was obtained immediately as requested. [Note: Review of laboratory studies on January 9, 2008 at approximately 1:20 PM revealed that the lithium level was not obtained until December 6, 2008.] 3. The facility's nursing services failed to ensure that Client #2's Vitamin D 25-OH T, Vitamin D 25-OH D3 and Vitamin D 25-OH D2 levels were obtained in a timely manner as evidenced below: Review of the physician's progress note dated December 4, 2007on January 9, 2008 at approximately 11:05 AM revealed that Client #2 had a diagnosis of Vitamin D deficency. Further review revealed that Client #2 was prescribed Vitamin D 50,000 Iu 1.25 mg by mouth once a week times twelve weeks. Review of the Medication Administration Record (MAR) dated January, 2008 at approximately 4:27PM revealed that Client #2 was prescribed Vitamin D 50,000 Iu 1.25 mg by mouth once a week times twelve weeks. Review of a laboratory study dated September 25, 2007 on January 9, 2008 at approximately 9:38 AM revealed a recommendation that Client #2 have Vitamin D 25-OH T, Vitamin D 25-OH D3 and Vitamin D 25-OH D2 levels repeated in twelve weeks. In an interview with the LPN on January 9, 2008 at approximately 12:45PM it was acknowledged that the Vitamin D 25-OH T, Vitamin D 25-OH D3 and Vitamin D 25-OH D2 levels had not been repeated as recommended. Review of laboratory studies on January 9, 2008 at approximately	W 338		

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W 338	Continued From page 18 10:30AM revealed that there were no available Vitamin D 25-OH T, Vitamin D 25-OH D3 and Vitamin D 25-OH D2 levels documented since September 25, 2007. There was no documented evidence that the Vitamin D 25-OH T, Vitamin D 25-OH D3 and Vitamin D 25-OH D2 levels were obtained or scheduled in a timely manner. 4. The facility's nursing services failed to ensure that Client #2's ANA level was obtained in a timely manner as evidenced below: Review of the physician's order sheet (POS) dated Auquest 23, 2007on January 9, 2008 at approximately 8:10 AM revealed that Client #2 was ordered an ANA [microalbumin urine] level to be obtained. Further review revealed a recommendation for Client #2 to be referred for a nephrology consult because of abnormal renal function tests. Review of the physician's progress note dated December 4, 2007on January 9, 2008 at approximately 11:07 AM revealed a recommendation that have an ANA [microalbumin urine] level obtained prior to his nephrology follow-up on December 17, 2007. In an interview with the LPN on January 10, 2008 at approximately 11:45AM it was acknowledged that the ANA levels had been drawn; however the hospital failed to send the facilty the results of the ANA levels. Review of laboratory studies on January 9, 2008 at approximately 10:30AM revealed that there was no documented ANA levels available in the medical record. There was no documented evidence that the client's ANA levels were obtained in a timely manner.	W 338		
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with	W 368		

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W 368	Continued From page 19 the physician's orders. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that medications were given in compliance with the physician's orders for one of two clients in the sample. (Client #2) The finding includes: Review of a nephrology consult dated December 17, 2007, on January 9, 2008 at approximately 11: 00AM revealed that Client #2 had a diagnosis of stable chronic kidney disease, Stage 2 probably from lithium toxicity due to long standing use. Further review recommended "need to consider other alternatives to lithium." Review of the psychotropic medication review dated December 19, 2007on January 9, 2008 at approximately 11:10 AM revealed a recommendation to decrease and discontinue lithium over three weeks. Review of the physician's order sheet (POS) dated December 19, 2007 on January 9, 2008 at approximately 11:30 AM revealed an order to administer Lithium 300mg twice a day, times seven days. Further review revealed an order to than administer Lithium 150mg twice a day, times seven days. Review of the Medication Administration Record (MAR) dated December 1, 2007 on January 9, 2008 at approximately 12:00 PM revealed that Client #2 was administered Lithium 300mg twice a day by mouth from December 19, 2007at 5:00 PM to December 26, 2007 at 5:00 PM. Further review revealed that Client #2 was also administered Lithium 150mg by mouth on December 26, 2007 at 5:00PM. In an interview with the Licensed Practical Nurse (LPN) on	W 368		

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W 368	Continued From page 20 January 10, 2008 at approximately 11:30AM it was acknowledged that the documentation on the MAR revealed that Client #2, had recieved Lithium 300mg and Lithium 150 mg by mouth on December 26, 2007 at 5:00 PM. Further interview revealed that the LPN did not think that Client #2 actually was administered Lithium 450mg by mouth on December 26, 2007 at 5:00PM. There was no evidence that the medication prescribed by the physician was given in compliance with the physician's orders.	W 368		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to hold evacuation drills quarterly on all shifts. The finding includes: Interview with the Program Manager (PM)/Acting Qualified Mental Retardation Professional (QMRP) and review of the staffing pattern on January 7, 2008 at approximately 2:15 PM revealed the scheduled shifts are as follows: Weekdays 1st Shift 8 AM to 4 PM 2nd Shift 2 PM to 10 PM 3rd Shift 10 AM to 8 AM Weekends/Saturday and Sunday 1st 8 AM to 4 PM 2nd 4 PM to 12 AM	W 440		

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W 440	Continued From page 21 3rd 12 AM to 8 AM Further interview with the PM/QMRP revealed that the staff was required to conduct a drill once per month on each shift. Review of the fire drill log book from February 2007 to January 2008 revealed that the facility failed to hold simulated fire drills at least four times a year for each shift during the periods of February 2007 through April 2007. There was no evidence that fire drills were conducted quarterly on all shifts.	W 440		